MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10326

Reg. Dist. No. 166

10336

1. PLACE OF DEATH
a. COUNTY Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Oakland
c. LENGTH OF STAY IN 1b —
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deep Creek Lake-Route 219

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Swanton
d. STREET ADDRESS Rural delivery
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print) First NEVA Middle LOUISE Last BOWERS

4. DATE OF DEATH Month 10 Day 21 Year 1956

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 4-2-40
9. AGE (In years last birthday) 16 yrs.
IF UNDER 1 YEAR Months — Days —
IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student
10b. KIND OF BUSINESS OR INDUSTRY High School
11. BIRTHPLACE (State or foreign country) Bayard W Va
12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME Paul J. Bowers
14. MOTHER'S MAIDEN NAME Goldie Shrere

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Address Paul J Bowers - Swanton Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Drowning — INTERVAL BETWEEN ONSET AND DEATH minutes
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
Fracture Rt. Femur, Fracture Lt. tibia + fibula, Multiple Lacerations
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☑ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto Accident - auto fell in water + she was trapped
20c. TIME OF INJURY Hour 12:30 a. m. p. m. Month, Day, Year 10/21 1956
20d. INJURY OCCURRED While at work ☐ Not while at work ☑
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 219
20f. (City or town) near Oakland, (County) Garrett, (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Thomas J Lusby M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED 10/21/56
EXAMINER'S NAME (Type) THOMAS F. LUSBY M.D. Acting

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10/23/1956
22c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery
22d. LOCATION (City, town, or county) (State) Deer Park, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton ADDRESS Oakland, Md.
24a. REC'D BY REGISTRAR DATE
24b. REGISTRAR'S SIGNATURE Julia M. Brown

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10337 166

10337

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OAKLAND
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GARRETT COUNTY MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL OAKLAND
d. STREET ADDRESS: STAR ROUTE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ZELPHIA — Middle — Last FRIEND

4. DATE OF DEATH: Month OCTOBER — Day 25 — Year 19 56

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JUNE-12-1885
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MEADOW MT MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: JOHN KNOX
14. MOTHER'S MAIDEN NAME: SARAH GREEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ALBERT FRIEND — Address: OAKLAND MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Bronchopneumonia	3 Days
DUE TO (b)	Cerebral Hemorrhage & Rt Hemiplegia	6 Days
DUE TO (c)	Arteriosclerosis	5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

331x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from OCTOBER 23, 1956, to OCTOBER 25, 1956, that I last saw the deceased alive on OCTOBER 25, 1956, and that death occurred at 10:18A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A E Vance M.D. — ADDRESS (Street, city or town, state): Oakland Md — DATE SIGNED: 25 Oct 56

PHYSICIAN'S NAME (Type): ANDREW E. VANCE, M. D. — OAKLAND, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: Oct-27-1956
22c. NAME OF CEMETERY OR CREMATORY: GLENDALE CEMETERY
22d. LOCATION (City, town, or county) (State): NEAR SWANTON MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Emroy Baldwin — ADDRESS: OAKLAND MD.

24a. RECD BY REGISTRAR DATE: 10/27/56
24b. REGISTRAR'S SIGNATURE: Elizabeth Fazenbaker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10328

10338

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH
a. COUNTY: GARRETT Co — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OAKLAND
c. LENGTH OF STAY IN 1b: 3YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WEEKS NURSING HOME.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: W. VA — b. COUNTY: GRANT Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BAYARD W.VA. 85 x-3
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNIE — Middle HILL — Last GUTHRIE

4. DATE OF DEATH: Month OCT. — Day 13 — Year 1956

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: AUG-13-1860

9. AGE (In years last birthday): 96 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): UPPER TRACT W.VA

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: GEORGE HILL

14. MOTHER'S MAIDEN NAME: CAROLINE SHREVES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: MRS. GEORGE FULK. BAYARD W.VA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 years

420.0

DUE TO (b) Hypertensive Heart Disease — 5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Arteriosclerotic Heart Disease — 10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 5:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Andrew E. Thomas M.D. — ADDRESS (Street, city or town, state): Oakland Md — DATE SIGNED: 10-14-56

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 22b. DATE THEREOF: Oct-16-1956 — 22c. NAME OF CEMETERY OR CREMATORY: BAYARD CEMETERY — 22d. LOCATION (City, town, or county) (State): BAYARD W.VA.

23. FUNERAL DIRECTOR'S SIGNATURE: Emory Boldin — ADDRESS: OAKLAND MD.

24a. REC'D BY REGISTRAR DATE: 10/15/56 — 24b. REGISTRAR'S SIGNATURE: Julia Rowen

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10329

10339

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GRANTSVILLE, MD
c. LENGTH OF STAY IN 1b: 30 YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GRANTSVILLE, MD
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: ELIZABETH Middle: Last: HOCKMAN

4. DATE OF DEATH: Month: OCT Day: 17 Year: 1956

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: JUNE 17 1874

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): SOMERSET Co, PA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SAMUEL RINGER

14. MOTHER'S MAIDEN NAME: MELINDA KRETCHMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Address: Mrs Harry Collier, Accident Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: instantly
DUE TO
(b): Arteriosclerosis — 10 yr.
DUE TO
(c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): NO accident

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —

20f. (City or town) (County) (State) —

21. I certify that I attended the deceased from Aug 14, 1956, to Oct 17, 1956, that I last saw the deceased alive on Oct 12, 1956, and that death occurred at 2:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C W Stotler, M.D. M.D.

ADDRESS (Street, city or town, state):

DATE SIGNED: Oct 19, 1956

PHYSICIAN'S NAME (Type): C. W. STOTLER, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 10/20/56

22c. NAME OF CEMETERY OR CREMATORY: COVE LUTHERAN

22d. LOCATION (City, town, or county): (State): RURAL ACCIDENT MD

23. FUNERAL DIRECTOR'S SIGNATURE: Donald J Newman, ADDRESS: Grantsville Md

24a. REC'D BY REGISTRAR DATE: OCT 24 1956

24b. REGISTRAR'S SIGNATURE: L. N. Hedrick

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10340 — Reg. Dist. No. 1030

1. PLACE OF DEATH
a. COUNTY: GARRETT Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ACCIDENT
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD — b. COUNTY: GARRETT Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FRIENDSVILLE. RURAL
d. STREET ADDRESS: STAR ROUTE
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle H — Last KISSNER
4. DATE OF DEATH: Month OCTOBER — Day 19 — Year 1956

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
MALE	WHITE	WIDOWED ☒	JULY-11-1881	95 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WOODSMAN
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): FRIENDSVILLE MD
12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: JAMES O. KISSNER.
14. MOTHER'S MAIDEN NAME: MARY WAYBLE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-18-2836
17. INFORMANT: RALPH KISSNER — Address: FRIENDSVILLE MD STAR RT.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH:
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, o. m. / p. m., Month, Day, Year 19	20d. INJURY OCCURRED: While at work ☐ / Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E. L. Baumgartner M.D. — CHIEF MEDICAL EXAMINER ☐ / ASSISTANT MEDICAL EXAMINER ☐ / DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED
EXAMINER'S NAME (Type): E. L. BAUMGARTNER M.D. — OCT. 20-1956

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)
BURIAL	Oct-22-1956	FRIENDSVILLE CEMETERY	FRIENDSVILLE	MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Emroy Baldwin — ADDRESS: OAKLAND MD
24a. REC'D BY REGISTRAR — DATE: Oct. 22. 56
24b. REGISTRAR'S SIGNATURE: Mrs. Ruth Frantz Dep.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

RECEIVED
OCT 25 1956
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10341

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CARLOD
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GARRETT COUNTY MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTERNPORT
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: GEORGE — Middle: ANDREW — Last: MEESE

4. DATE OF DEATH: Month: OCTOBER — Day: 11, — Year: 1956

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: DECEMBER 15, 1878

9. AGE (In years last birthday): 77 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal-Mine

11. BIRTHPLACE (State or foreign country): Aarons Run, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: NELSON H. MEESE

14. MOTHER'S MAIDEN NAME: MARY SIGLER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: MRS. CHARLES LEW ELLIOTT — Address: MC COOLE, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: Oct 4/56

4991

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Art. C. V. D. — years

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile Dementia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 13, 1956 to Oct 14, 1956 that I last saw the deceased alive on Oct 14, 1956, and that death occurred at 5:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas F Ilsley M.D. — ADDRESS (Street, city or town, state): — DATE SIGNED: 10/14/56

PHYSICIAN'S NAME (Type): THOMAS F. ILSLEY M.D. — ADDRESS: [illegible] OAKLAND, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 10/17/56 — 22c. NAME OF CEMETERY OR CREMATORY: Meese Cem — 22d. LOCATION (City, town, or county) (State): Allegany Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE: Ellsworth E. Boal — ADDRESS: Westernport Md — 24a. REC'D BY REGISTRAR DATE: 10/17/56 — 24b. REGISTRAR'S SIGNATURE: Virgil H. Rowan Jr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG205 10-29-56 et

10332

CERTIFICATE OF DEATH

10342

Reg. Dist. No. 9

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural-Frostburg
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg, R.F.D. 2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY — Middle ELLEN — Last MORGAN

4. DATE OF DEATH: Month October — Day 14 — Year 19 56

5. SEX: Female famel

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6-25-1871

9. AGE (In years last birthday): 85 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Tobias Foutz

14. MOTHER'S MAIDEN NAME: Annie Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT (Address): Mrs. Annie Giles, Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cyanosis Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month — Day — Year 19

20d. INJURY OCCURRED: White at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from July, 19 54, to Oct 14, 19 56, that I last saw the deceased alive on October 14, 19 56, and that death occurred at 2:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John B. Davis, M.D. — ADDRESS (Street, city or town, state): 2 Block E. Main St. Frostburg, Md. — DATE SIGNED: 10/15/56

PHYSICIAN'S NAME (Type): John B. Davis, MD — Frostburg, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-17-56

22c. NAME OF CEMETERY OR CREMATORY: F'bg. Memorial Park

22d. LOCATION (City, town, or county) (State): Frostburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. R. Durst, — ADDRESS: Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: 10-17-56

24b. REGISTRAR'S SIGNATURE: Mrs. Nancy N. Roe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10343 **CERTIFICATE OF DEATH** Reg. Dist. No. 10333

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Grantsville, Md.
c. LENGTH OF STAY IN 1b: 50 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Grantsville, Md.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Stewart Middle Rodamer Last (POWER)

4. DATE OF DEATH: Month Oct. Day 22 Year 1956

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 9, 1891
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Bank cashier
11. BIRTHPLACE (State or foreign country): Somerset Co., Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Cyrus Rodamer
14. MOTHER'S MAIDEN NAME: Lydia Yoder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 216-03-8653
17. INFORMANT Address: Mrs. Orpha Rodamer, Grantsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lympho-sarcoma — INTERVAL BETWEEN ONSET AND DEATH: 2 years
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): NO
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1948, to Oct 20, 1956, that I last saw the deceased alive on Oct 20, 1956, and that death occurred at 6:30 PM, from the causes and on the date stated above.
ACTUAL SIGNATURE: C W Stotler MD M.D.
ADDRESS (Street, city or town, state): 349 Main St. Meyersdale, Pa
DATE SIGNED: 10/24/56
PHYSICIAN'S NAME (Type): C. W. STOTLER MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/23/56
22c. NAME OF CEMETERY OR CREMATORY: Grantsville
22d. LOCATION (City, town, or county) (State): Grantsville, Garrett Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Donald J Newman
ADDRESS: Grantsville, Md.
24a. REC'D BY REGISTRAR DATE: OCT 25 56
24b. REGISTRAR'S SIGNATURE:

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10344

10334

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakland
c. LENGTH OF STAY IN 1b: 25 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GARRETT COUNTY MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: WEST VIRGINIA
b. COUNTY: GRANT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BAYARD
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First BERTHA Middle FLORENCE Last SPENCER

4. DATE OF DEATH: Month OCTOBER Day 5, Year 1956

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: DEVEMBER 19, 1886

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: KENNETH HILL

14. MOTHER'S MAIDEN NAME: ELIZABETH AYERS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: HENRY T. SPENCER Address: BAYARD, WEST VIRGINIA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 26 Days

420.1

DUE TO (b) Coronary Heart Disease — 3 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 18, 19 55, to October 5, 19 56, that I last saw the deceased alive on October 4, 19 56, and that death occurred at 6:00 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Andrew E. Mance M.D. ADDRESS (Street, city or town, state): Oakland Md DATE SIGNED: 5 Oct 56

PHYSICIAN'S NAME (Type): ANDREW E. MANCE, M.D. OAKLAND, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: Oct-7-1956

22c. NAME OF CEMETERY OR CREMATORY: BAYARD CEMETERY

22d. LOCATION (City, town, or county) (State): BAYARD W. VA.

23. FUNERAL DIRECTOR'S SIGNATURE: Emery Bolden ADDRESS: OAKLAND MD.

24a. REC'D BY REGISTRAR DATE: 10/6/56

24b. REGISTRAR'S SIGNATURE: Helen L. Swan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10335

CERTIFICATE OF DEATH

10345

Reg. Dist. No.....

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY: Garrett — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Friendsville (Rural)

LENGTH OF STAY (in this place): Lifetime

HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland COUNTY: Garrett

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Friendsville (Rural)

STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Katherine (Middle) (Last) Teats

4. DATE OF DEATH: (Month) 10 (Day) 22 (Year) 19 56

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	2/2/1864	92 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Maryland	U.S.A.

13. FATHER'S NAME: William E. Friend

14. MOTHER'S MAIDEN NAME: Mary Ann Friend

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No			Gay Teats, Friendsville, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 IMMEDIATE CAUSE (A) Uremia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Generalized Arteriosclerosis

DUE TO (C) Arteriosclerotic Heart Disease

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 19 56 to 1 visit, 19....., that I last saw the deceased alive on June 19, 19 56 and that death occurred at 6 A M, from the causes and on the date stated above.

SIGNATURE Harold Kamons M.D. ADDRESS (Street, city, town, state) R.D. Mar Kleysburg, Pa. DATE SIGNED 10-22-56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10/24/1956	Friendsville,	Friendsville, Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
Oct. 23-1956	Mrs Ruth Frantz Dep.	Jack A Friend, Friendsville